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Montana Small
Employer Carrier
Reinsurance
Program

Montana Small Employer Carrier Reinsurance Program

A Report from the Montana Commissioner of Insurance to the Governor and 54th Montana Legislature

March 1, 1995

State Auditor Mark O'Keefe

Commissioner of Insurance and Securities

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A REPORT BY THE MONTANA COMMISSIONER OF INSURANCE TO THE GOVERNOR AND 1995 LEGISLATURE ON THE SMALL EMPLOYER CARRIER REINSURANCE PROGRAM

SUMMARY

This report is being submitted in compliance with 33-22-1819. It covers the operations of the Montana Small Employer Carrier Reinsurance Program through December 31, 1994.

Beginning in August 1993 and running through December 1994, the Reinsurance Program prepared for full operation, complying with the provisions of the code that require appointment of a board of directors, adoption of a plan of operation, selection of an administering carrier, and establishment of premium rates.

Insurance companies were able to purchase reinsurance coverage beginning December 7, 1994. No lives were ceded to the reinsurance program and no premium was collected during the 22 days the program was operational in 1994.

The 1993 legislature provided an appropriation to the State Auditor's Office that included funding for the administrative costs of the board in fiscal 1994 and 1995. There are no administrative costs that required an assessment in 1994.

ESTABLISHMENT OF THE PROGRAM

1993 Legislature Establishes the Montana Reinsurance Program

As part of the Montana Small Employer Health Insurance Availability Act in Senate Bill 285, the Legislature established a reinsurance program. The act is based on model legislation designed by the National Association of Insurance Commissioners and adopted by 33 other states. The reinsurance program is an important component of this model insurance reform as a way to help spread the cost of guaranteed issue insurance and minimize increases in health insurance rates.

Selection of the Board

By statute the board of the Montana Small Employer Carrier Reinsurance Program must have nine members, consisting of six insurance carriers, a small employer, a health care provider, and a consumer. Five of the six insurance carriers represent companies selling the most health insurance coverage to small groups in Montana. The sixth carrier is chosen at the discretion of the Insurance Commissioner.

In August 1993, the Department of Insurance sent a survey to all licensed health insurance carriers in Montana to determine a ranking of carriers with the highest total premiums from small group health policies for 1992. On the basis of that survey the following companies were offered seats on the Board: Montana Blue Cross Blue Shield; John Alden Life Insurance; Travelers Insurance; Principal Mutual Life; and Continental Life & Accident. All carriers except Travelers Insurance accepted a position on the Board. Western Mutual Insurance was the next carrier in the ranking to accept a board seat.

Insurance Commissioner Mark O'Keefe appointed Mutual of Omaha as the sixth insurance carrier because of their extensive experience helping other states start up reinsurance programs. A provider from Kalispell, a small businessman from Great Falls and a consumer from Helena were appointed to the remaining board seats. Attachment A includes a list of Board members and their terms of office.

Plan of Operation

The board first met in November 1993, and then met monthly for the first four months of 1994 to work on the Plan of Operation. The board representative from Mutual of Omaha provided a starting draft, which combined the best parts from the plan of operation in other states. The board worked on modifications to the draft through its April meeting, when the final version was adopted. (See Attachment B) The Insurance Department then promulgated the Plan of Operation as administrative rules. A hearing on these rules was held on July 6, 1994. The Department received little comment. Commissioner Mark O'Keefe adopted final rules for the reinsurance program effective August 12, 1994.

Selection of an Administering Carrier

With assistance from the Department of Administration's Purchasing Division and Department of Insurance staff, a sub-committee of the board designed a request for proposal (RFP) to select an administering carrier. Notice regarding the RFP was mailed to about 70 potentially interested parties. The board received one proposal -- from Travelers Insurance.

The board met to review Travelers' proposal. The board selected Travelers as the administering carrier because of its experience administering reinsurance programs in 17 other states. The contract with Travelers was finalized at a meeting of the board in September. (See Attachment C.) Duties of the administering carrier are listed in the Plan of Operation and the RFP.

Reinsurance Premium Rates

Premium rates for reinsurance coverage are set by the board. The Department of Insurance actuary worked for more than 10 weeks with an actuarial committee from five of the carriers represented on the board. The actuarial committee finalized their recommended rates at a meeting on Oct. 20, 1994. The board adopted the recommended premium rates at its Oct. 28, 1994 meeting. Rates for Medicare primary policies were adopted in a conference call in November. (See Attachment D -- All reinsurance premium rates.)

The board adopted reinsurance premium rates to cover most expected claim costs. The methodology used to establish the rates was similar to that used by Idaho's program.

Program Operational

On Dec. 7, 1994 the Montana Reinsurance Program became operational. This was also the first day insurers were required to be certified as small group carriers and offer guaranteed issued products. All active health insurance carriers were notified about the availability of reinsurance through the program. On Dec. 14 and 15, 1994 the administering carrier conducted a workshop for carriers. Operations and procedures manuals were sent to every carrier requesting a copy.

The Reinsurance Program offers coverage to all certified small group carriers. Attachment E lists Montana's small group carriers. Most major insurers previously in the small group market elected to stay in the market. More carriers can still elect to get into the market.

ANNUAL REPORT FOR 1994

The administering carrier, Travelers Insurance, provided an annual report of activities for 1994 to the board at its annual meeting on Feb. 7, 1995. A copy of the report is Attachment F. This report contains a financial report for the year.

COSTS, ASSESSMENTS & PREMIUMS COLLECTED

Program Costs

An appropriation by the 1993 Legislature provided funds for starting up the Montana Reinsurance Program in fiscal years 1994 and 1995. The costs related to operation and maintenance of the reinsurance program in calendar year 1994 are as follows:

Board Travel	$ 15,847.18
Board Honoraria	$ 425.00
Postage	$ 1,909.71
Printing	$ 1,813.22
Conference Calls	$ 930.42
Meeting expenses	$ 475.45
Total	***$ 21,400.98***

The State Auditor's Office provided staff to organize board activities, and to do legal, clerical and actuarial work. These personnel services costs were provided by an appropriation made directly to the State Auditor's Office.

Beginning in fiscal year 1996 the reinsurance board will pay $10,000 a year for staff support and an additional $10,000 a year for actuarial support from the State Auditor's staff. The State Auditor's Office will track the time spent in direct support of the reinsurance program to develop a better cost basis for future years.

The contract with the administering carrier provides for deferred payment of costs incurred in 1994 and a penalty for early cancellation of the contract. Those costs and penalties are stipulated in the contract with the administering carrier in Attachment C.

Assessments

There were no assessments made for administrative costs or losses in 1994. (See Attachment F)

Premiums Collected

There were no premiums collected in 1994. (See Attachment F)

PREMIUM APPROPRIATENESS

Reinsurance premiums were set by the board based on a recommendation from the actuarial committee. The Department of Insurance actuary worked with an actuarial committee with representatives from five of the carriers on the board. Rates were set at a level predicted to cover the anticipated costs assuming an in-force ceded population of at least 40 to 50 lives.

The premium rates were derived from pricing assumptions and techniques appropriate for Montana expected experience from the 1994 Tillinghast Group Medical Insurance Rate Manual. First, the average net price of the standard health plan and of four average basic health plans were calculated, based on the benefits in the plans, the cost-sharing provisions such as deductible, coinsurance and copayments, and the average expected health costs for Montana relative to other parts of the country.

Then the net reinsurance rates were calculated using the same assumptions except for the cost-sharing provisions, which were revised to match the cost-sharing between the insurance company and the reinsurance program.

An analysis was done to check the reasonableness of the resulting premium rates. Idaho's reinsurance program was chosen as an appropriate standard with which to compare Montana's program. The same process described above was used to calculate the net reinsurance rates appropriate for Idaho's reinsurance program. These rates were then compared to the reinsurance premiums that the Idaho reinsurance program actually charges. The result was that the Idaho net reinsurance rates needed to be increased by an average of 23% to match the actual Idaho reinsurance program rates.

The Montana net reinsurance rates were then increased by 23%. They were further checked for reasonableness by comparing them with the reinsurance program rates of other states. The comparison shows that out of 18 states, Montana's rates are lower than 12 states' rates and higher than those of 5 states. The comparison did not take into account the difference in standard and basic plans, the reinsurance program provisions, or health care costs among the various states; but on the average, the result would be the same.

The reinsurance premiums for indemnity plans with PPO options were decreased by 10% to reflect the lower negotiated health care costs for insured individuals who used the member providers. The HMO reinsurance rates were calculated by comparing the benefits, expected claim costs, and cost-sharing provisions between the standard HMO and the standard indemnity plan. The difference was estimated to be about 7% higher than the value of the indemnity plan with a PPO option; so the HMO reinsurance rates were set 7% higher than those for the standard indemnity plan with a PPO option. Likewise the basic HMO rate was set 7% higher than the highest-value average basic indemnity plan with a PPO option.

The appropriateness of the premiums cannot yet be judged from actual experience. However, they are deemed to be appropriate based on the assumptions and knowledge available at the time the pricing was done.

INSURANCE RETENTION BY CARRIERS

Because no lives were ceded to the reinsurance program in 1994, insurance retention by carriers was 100%.

COST OF COVERAGE OF SMALL EMPLOYERS

To establish a baseline of the cost of coverage of small employers the State Auditors Office conducted a survey of small employers during the summer of 1994.

The survey showed that small businesses (with between 3 and 25 employees) are less likely to provide health insurance coverage to employees than large businesses. Less than half -- 47 percent -- of small businesses in Montana said they provided health insurance coverage to their workers, while 83 percent of large businesses reported they provided health insurance coverage to their employees.

The survey also showed that small employers pay more to provide health insurance coverage to their workers than do large businesses.

RECOMMENDATIONS

The State Auditor proposes the following recommendations concerning the Montana Reinsurance Program:

1) The reinsurance program cover all of its operational costs from assessments and/or premiums rather than from a general fund appropriation. The board has agreed with the recommendation and plans to assess for administrative costs beginning July 1, 1995. The State Auditor has not requested an appropriation for the reinsurance programs operation for the 1996-97 biennium.

2) The Legislature should consider increasing the size of groups that can participate in small group reform. Various organizations have advocated expanding the definition of a small group to include individual coverage and groups of two. Other organizations have recommended the ceiling be expanded from 25 to 100.

The Reinsurance Board adopted the following policy statement and recommendation to the Montana Legislature which was presented to the House Select Committee on Health Care:

STATEMENT TO THE HOUSE SELECT COMMITTEE ON HEALTH CARE

FROM THE MONTANA REINSURANCE BOARD

February 7, 1995

TODAY THE BOARD FOR THE MONTANA SMALL GROUP CARRIER REINSURANCE PROGRAM HELD ITS ANNUAL MEETING. WE HEARD FROM PARTIES CONCERNED ABOUT APPROPRIATE LEVELS FOR THE REINSURANCE RATES AND WHETHER IT IS BEST TO HAVE A SYSTEM WITH GUARANTEED ISSUE POLICIES AND A REINSURANCE PROGRAM OR USE A HIGH RISK INSURANCE PROGRAM LIKE THE MONTANA COMPREHENSIVE HEALTH CARE ASSOCIATION TO PROVIDE HEALTH CARE COVERAGE FOR THE MEDICALLY UNINSURABLE. OUR BOARD TAKES THE FOLLOWING POSITION ON THESE ISSUES:

FIRST, WE BELIEVE THAT THE PREMIUM RATES SET, ONLY THIS FALL, ARE FAIR AND MID-RANGE COMPARED TO RATES WITH COMPARABLE PROGRAMS. WE WILL EVALUATE RATES AS NEEDED BASED ON THE EXPERIENCE OF THE PROGRAM.

SECOND, WE BELIEVE THAT THE REINSURANCE MECHANISM STABILIZES THE MARKET AND MINIMIZES THE COST OF GUARANTEED ISSUE. THE REINSURANCE PROGRAM ENCOURAGES INSURANCE COMPANIES TO STAY IN THE MARKET.

FURTHER, WE STRONGLY DO NOT ENDORSE ISOLATING INDIVIDUALS INTO A HIGH RISK POOL LIKE THE MCHA AS A WAY TO PROVIDE COVERAGE FOR THE MEDICALLY UNINSURABLE.

FINALLY, WE SUPPORT A STANDARD PLAN THAT HAS UNIFORM BENEFITS AND ALLOWS FOR THE CONSUMER TO COMPARISON SHOP. TO ALLOW A STANDARD PLAN WITH VARIABLE BENEFITS WOULD PROVIDE PROBLEMS FOR REINSURANCE.

APPENDIX

A. Board Members and Terms of Office

B. Plan of Operation

C. Contract with Travelers Insurance

D. Reinsurance Premium Rates

E. Certified Small Group Carriers

F. 1994 Annual Report

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ATTACHMENT A

BOARD MEMBERS - TERM OF OFFICE

MONTANA SMALL GROUP REINSURANCE BOARD

Merle Pederson
Martha Crist
Principal Mutual Life
Insurance Company
2 year term

Ray Havig
Western Mutual Insurance
Company
2 year term

Patrick Carmody
Rebecca Smart
Mutual of Omaha
1 year term

Hank Frantz
John Alden Life Insurance
3 year term

Garth Trusler
Bill Jensen
Blue Cross Blue Shield of
Montana
3 year term

Carl Halcro
Carl's EXXON
1 year term

Sherry Abel
Kalispell Regional Hospital
3 year term

Christian MacKay
Consumer Representative
1 year term

Merle Colpron
Continental Life & Accident
2 year term

New Board members are appointed June 1 of each year. All appointments are for three years beginning in 1995.

ATTACHMENT B

PLAN OF OPERATION

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

PLAN OF OPERATION

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MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM
PLAN OF OPERATION

I Article I - Name

The Program shall be known as the Montana Small Employer Health Reinsurance Program, hereinafter referred to as the Program, a nonprofit entity created pursuant to 33-22-1818, MCA, commonly known as the Montana Small Employer Group Health Insurance Availability Act, hereinafter referred to as the Act.

II Article II - Members of Program

All Reinsuring Carriers (as defined in 33-22-1803(23), MCA) issuing or providing health benefit plans in this state are members of the Program.

III Article III - Purpose

The purposes of the Program are:

A. To promote the availability of health insurance coverage to small employers regardless of health status or claims experience.

B. To provide reinsurance as a mechanism to fairly share the risk.

C. To improve the overall efficiency and fairness of the small employer health insurance marketplace.

IV Article IV - Definitions

As used in this Plan:

A. **Administering Carrier** means either a third party administrator, a carrier, or any other entity approved by the Commissioner.

B. **Actuarial Certification**, as defined in 33-22-1803(1), MCA, means a written statement by a Member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a Small Employer Carrier is in compliance with the provisions of 33-22-1809, MCA, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the Small Employer carrier in establishing premium rates for applicable Health Benefit Plans.

C. **Affiliate or Affiliated** means a person, firm, corporation, partnership or association who directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with, a specified person, firm, corporation, partnership or association.

D. **Assessable Carrier**, as defined in 33-22-1803(3), MCA, means all individual carriers of disability insurance and all carriers of group disability insurance, excluding the state group benefits plan provided for in Title 2, Chapter 18, Part 8, the Montana University System Health Plan, and any self-funded disability insurance plan provided by a political subdivision of the state.

E. **Base Premium Rate**, as defined in 33-22-1803(4), MCA, means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for

that class of business, by the Small Employer Carrier to Small Employers with similar case characteristics for Health Benefit Plans with the same or similar coverage.

F. **Basic Health Benefit Plan**, as defined in 33-22-1803(5), MCA, means a lower cost Health Benefit Plan developed pursuant to 33-22-1812, MCA.

G. **Board** means the Board of Directors of the Program established pursuant to 33-22-1818, MCA.

H. **Carrier** means any person who provides a Health Benefit Plan in the state subject to state insurance regulation. The term includes, but is not limited to, an insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement.

I. **Commissioner** means the Insurance Commissioner of the state of Montana.

J. **Covered Claims** shall mean only such amounts as are actually paid by the Members for benefits provided for individuals reinsured by the Program, but Covered Claims shall not include:

1. Claim expenses or salaries paid to employees of the Members who are not providers of health care services;

2. Court costs, attorney's fees or other legal expenses;

3. Any amount paid by the Members for:

   a. Punitive or exemplary damages; or

   b. Compensatory or other damages awarded to the Insured, arising out of the conduct of the Members in the investigation, trial, or settlement of any claim or failure to pay or delay in payment of any benefits under any policy; or the operation of any managed care, cost containment, or related programs;

4. Any statutory penalty imposed upon a Member on account of any unfair trade practice or any unfair insurance practice.

K. **Department** means the Insurance Department of the State of Montana.

L. **Dependent**, as defined in 33-22-1803(11), MCA, means:

1. A spouse or unmarried child under 19 years of age;

2. An unmarried child, under 23 years of age, who is a full-time student and who financially dependent on the insured;

3. A child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

4. Any other individual defined to be a dependent in the health benefit plan covering the employee.

M. **Eligible Employee**, as defined in 33-22-1803(12), MCA, means an employee who works on a full-time basis and who has a normal work

week of thirty hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a Health Benefit Plan of a Small Employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

N. **Extra Eligible Employee** means a covered employee of a small group employer who is not an eligible employee because he or she works less than 30 hours per week.

O. **Health Benefit Plan**, as defined in 33-22-1803(14), MCA, means any hospital or medical policy, or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a Health Service Corporation or issued under a Health Maintenance Organization subscriber contract. Health Benefit Plan does not include:

1. accident only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

2. coverage issued as a supplement to liability insurance, worker's compensation insurance, or similar insurance;

3. automobile medical payment insurance;

4. additionally Health Benefit Plan does not include hospital indemnity and fixed indemnity plans, effective 1/1/94.

P. **Health Maintenance Organization (HMO)**, as defined in 33-31-102(7), MCA, means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or group of providers.

For the purposes of 11 U.S.C § 109(b)(2) and (d), an HMO is a domestic insurance company, and therefore is excluded as a debtor under the bankruptcy act.

Q. **Late Enrollee**, as defined in 33-22-1803(16), MCA, means an Eligible Employee, Extra Eligible Employee, or Dependent who requests enrollment in a Health Benefit Plan of a Small Employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the Health Benefit Plan, provided that the initial enrollment period was a period of at least 30 days. However, an Eligible Employee or Extra Eligible Employee, or Dependent may not be considered a Late Enrollee if:

1. The individual meets each of the following conditions:

   a. The individual was covered under Qualifying Previous Coverage at the time of the initial enrollment;

   b. The individual lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

   c. The individual requests enrollment within 30 days after termination of the Qualifying Previous Coverage.

2. The individual is employed by an employer that offers multiple Health Benefit Plans and the individual elects a different Plan during an open enrollment period; or

3. A court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's Health Benefit Plan and a request for enrollment is made within thirty days after issuance of the court order.

R. **Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

S. **Member** means each reinsuring Carrier participating in the Program.

T. **Plan of Operation** means the Plan of Operation of the Program, including articles, bylaws and operating rules, adopted by the Board pursuant to 33-22-1819, MCA.

U. **Premium** means the premium or subscriber payments for Health Benefit Plans as defined in 33-22-1803(19), MCA.

V. **Program** means the State Small Employer carrier reinsurance program created under 33-22-1818, MCA.

W. **Pre-existing Condition**, as defined in 33-22-110, MCA, means a condition for which medical advice or treatment was recommended by or received from a provider of health care services and the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months.

X. **Qualifying Previous Coverage**, as defined in 33-22-1803(21), MCA, means benefits or coverage provided under:

1. Medicare or Medicaid;

2. An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the Basic Health Benefit plans; or

3. An individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, health service corporation, or a Health Maintenance Organization, that provides benefits similar to or exceeding the benefits provided under the Basic Health Benefit Plan, provided that the policy has been in effect for a period of at least one year.

Y. **Reinsuring carrier**, as defined in 33-22-1803(23), MCA, means a small employer carrier participating in the Reinsurance Program pursuant to 33-22-1819, MCA.

Z. **Restricted Network Provision**, as defined in 33-22-1803(24), MCA, means a provision of a Health Benefit Plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to title 33, chapter 22, part 17, or title 33, chapter 31, to provide health care services to covered individuals.

AA. **Small Employer**, as defined in 33-22-1803(25), MCA, means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least fifty percent of its

working days during the preceding calendar quarter, employed at least 3 but not more than twenty-five Eligible Employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies are considered one employer if they:

1. are Affiliated companies;

2. are eligible to file a combined tax return for purposes of state taxation; or

3. are members of an association that:

   a. has been in existence for 1 year prior to January 1, 1994;

   b. provides a health benefit plan to employees of its members as a group; and

   c. does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group.

AB. **Small Employer Carrier** (hereinafter "**Carrier**"), as defined in 33-22-1803(26), MCA, means any Carrier which offers Health Benefit Plans that cover Eligible Employees of one or more Small Employers in this state.

AC. **Standard Health Care Plan** means a Health Benefit Plan developed under 33-22-1812, MCA.

AD. **Takeover Provisions** are provisions of a Health Benefit Plan offered by a carrier that is replacing the Health Benefit Plan of another carrier. These provisions apply to individuals who were insured under the replaced plan and address pre-existing conditions, deductible, carry forwards, and other items that minimize the inconvenience or loss of benefits or coverage that might occur during a replacement, in the absence of the Takeover Provisions.

AE. **Whole Group** means Eligible Employees, Extra Eligible Employees, and Dependents of a Small Employer.

V Article V - Powers of Program

Pursuant to 33-22-1819(4), MCA, the Program has the general powers and authority granted under the laws of this state to insurance companies and Health Maintenance Organizations licensed to transact business, except the power to issue Health Benefit Plans directly to groups or individuals. In addition, the Program may:

A. Enter into contracts as are necessary or proper to carry out the provisions and purposes of 33-22-1801 through 33-22-1822, MCA, including the authority, with the approval of the Commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions.

B. Sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of the Program, or against any reinsuring carriers. The Board will also consider suits pertaining to non-payment of assessments.

C. Take any legal action necessary to avoid the payment of improper claims against the Program.

D. Define the levels of reinsurance, up to the level of coverage provided in the standard health benefit plan, for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of 33-22-1801 through 33-22-1822, MCA.

E. Establish conditions and procedures for reinsuring risks under the Program.

F. Establish actuarial functions as appropriate for operation of this program.

G. To the extent permitted by Federal Law and in accordance with 33-22-1819(8)(c), MCA, assess members and make annual fiscal year-end assessments against Assessable Carriers, and make interim assessments to fund claims and administrative costs incurred by the Program.

H. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the Program, policy, contract design, and any other function within the authority of the Program.

I. Borrow money to effect the purposes of the Program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

J. Take any other action not otherwise inconsistent with law, but necessary for the administration of the Program.

VI Article VI - Program Plan of Operation

The Program shall perform its functions under this Plan of Operation and in accordance with the Act. The Plan of Operation must, pursuant to 33-22-1819(3):

A. establish procedures for the handling and accounting of Program assets and money and for an annual fiscal reporting to the Commissioner;

B. establish procedures for selecting an Administering Carrier and setting forth the powers and duties of the Administering Carrier;

C. establish procedures for reinsuring risks in accordance with the provisions of this section;

D. establish procedures for collecting assessments from Assessable Carriers to fund claims incurred by the Program;

E. establish procedures for allocating a portion of premiums collected from Reinsuring Carriers to fund administrative expenses incurred or to be incurred by the Program; and

F. provide for any additional matters necessary for the implementation and administration of the Program.

VII Article VII - Board of Directors and Annual Meeting of Members

A. Pursuant to 33-22-1818, MCA, the Program shall exercise its powers through a Board of Directors:

1. The Board shall consist of nine Directors appointed by the Commissioner (such representatives referred to hereinafter as Directors or the Board of Directors). At least six of the Directors of the Board must be representatives of small employer carriers, one from each of the five Small Employer Carriers with the highest annual premium volume derived from Health Benefit Plans issued to small employers in Montana in the previous calendar year and one from the remaining Small Employer Carriers. One Director must be a person licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of business or in the practice of a profession. One Director must be a Small Employer who is not active in the health care or insurance fields. One Director of the board must be a representative of the general public who is employed by a small employer and is not employed in the health care or insurance fields. The Commissioner or his designated representative serves as an ex-officio Director of the Board. The Commissioner's office shall be responsible for providing policy and administrative staff support to the Board.

2. Directors of the Board shall serve for a term of three years expiring on the first of June following their appointment. Board Directors shall serve out their terms even if the carrier they represent is no longer one of the five Small Employer Carriers with the highest annual premium volume (as set forth in Article VII(A)(1)). Pursuant to 33-22-1818(s)(a)(ii), MCA, the initial Directors' terms are as follows: one third of the members shall serve for a term of one year; one third of the members shall serve a term of two years; and one third of the members shall serve a term of three years. Subsequent Board members shall serve for a term of three years.

3. The Commissioner shall appoint a chair and a vice chair from among the Directors of the Board. The Board shall elect other officers as needed.

4. Vacancies occurring on the Board between annual meetings shall be appointed by the Commissioner with an appropriate person to fill the representational category for that seat. If one of the top five Carriers vacates a seat, the seat shall be offered to the next ranking Carrier until the vacancy is filled. If one of the top five Carriers turns down a seat and later reconsiders, such Carrier shall be given a seat only when there is a vacancy.

5. A Program Carrier, upon written notice to the Commissioner, may request a replacement Director of the Board representing said Program Carrier with a different representative approved by the Commissioner or designate an alternate, approved by the Commissioner, as needed.

   A vacancy on the Board must be filled by the Commissioner. The Commissioner may remove a Director for cause.

B. The votes of the Board shall be on a one person, one vote basis, but no carrier shall have more than one vote.

C. A majority of the Directors of the Board shall constitute a quorum for the transaction of business. The acts of the majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board, except as provided in Section I below. Directors are required to disclose any potential conflict of interest prior to voting on a particular issue. The Chair or his or her designee, with a majority vote of the Board, will decide whether or not the Director with the potential conflict may vote.

1. In the event that the chair and vice chair is absent from a board meeting the Commissioner shall appoint an acting chairman to carry out the duties of the chairman for the duration of the meeting.

2. A director who is not physically present, but who is in communication with the Board during its meeting may exercise his voting rights during the meeting.

D. An annual meeting of Members and the Board shall be held at the offices of the Commissioner on the first Tuesday in February of each year, unless the Board, upon at least a thirty (30) calendar day notice, designates some other date or place.

E. At each annual meeting the Board shall:

1. Review this Plan of Operation and submit proposed amendments, if any, to the Commissioner for approval.

2. Review reports of the Administering Carrier, including audited financial reports, reports on outstanding contracts and obligations, and all other material matters.

3. Review reports of the committees established by the Board.

4. Determine whether any technical corrections or amendments to the Act shall be recommended to the Commissioner.

5. Review and give consideration to the performance of the Program in support of the goals of the Act.

6. Review the rates for reinsurance coverages, benefit plan design and communication programs.

7. Review the net premiums, the Program administration expenses and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

8. Determine if an assessment is necessary for the proper administration of the Program.

9. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the Program.

10. Review and evaluate the contracts and services with the administrating carrier and staff. With support of 5 directors of the board, the contract will be renewed.

F. The Board shall hold other meetings upon the request of the chair or two or more Directors, at such times and with such frequency as it deems appropriate. These meetings may be held either in person or electronically. Notice of such a meeting and its purpose shall be provided to the Directors and the public at least seven (7) working days prior to the meeting, unless such notice shall be waived by unanimous consent of all Directors. At meetings other than the annual meeting, the Board may perform any of the functions listed in Section E above.

G. A written record of the proceedings of each Board meeting shall be made and submitted to the Board within 60 days of said meeting by the staff of the Board. Once the Board has approved minutes, a copy shall be submitted to the Commissioner.

H. Directors of the Board may be reimbursed from the monies of the Program for reasonable expenses incurred by them as members upon approval of such expenses by the Board, but shall not otherwise be compensated by the Program for their services.

I. Adoption of amendments to the Plan of Operation or suggestions of technical corrections to the Act shall require the concurrence of a majority of the entire Board and the approval of the Commissioner.

J. Review and act upon any other matters that the Board deems necessary so long as consistent with law and regulation.

VIII Article VIII - Committees

Pursuant to 33-22-1819(6), MCA, the Board shall appoint qualified individuals to any committee set forth in the Plan of Operation or otherwise established by the Board. A written record of the proceedings of each committee shall be maintained by a Secretary appointed from the membership of the committee. The Insurance Commissioner's office shall provide policy staff to each committee as appropriate and needed.

A. Actuarial Committee

The mission of the Actuarial Committee, pursuant to 33-22-1819(6), MCA, is to:

1. Recommend assessment methodology and assessments.

2. Recommend to the Board appropriate methodologies, reinsurance premium rates, rate schedules, rate adjustments, and rate classifications for individuals and groups reinsured with the Program.

3. Recommend to the Board reports to be made by Members and the Administering Carrier.

4. Provide reports and other recommendations as directed by the Board.

5. Determine the incurred claim losses of the Program including amounts for incurred but not reported claims.

6. Assist the Board in any other Actuarial-related matters that the Board deems necessary.

B. Operations Committee

The mission of the Operations Committee is to:

1. Periodically review this Plan of Operation and make recommendations to the Board.

2. Provide administrative interpretation as to the intent of this Plan of Operation and to provide administrative direction on issues referred to it by the Board of Directors or the Administering Carrier and Program Members. This committee shall provide administrative assistance in communicating the spirit and purpose of the Act.

3. Identify items for which operating rules are needed and to propose them for adoption by the Board.

4. Assist the Board in any other matters that the Board deems necessary.

C. Legal Committee

The mission of the Legal Committee is to handle the following legal matters at the request of the Board:

1. Interpret the provisions of the Act;

2. Review the Plan of Operation and amendments to the Plan of Operation;

3. Prepare proposed amendments to the Act for Board approval;

4. Coordinate with legal counsel for the Administering Carrier and Insurance Commissioner's office, as needed, on routine legal matters relating to the Program operations, including proposed contracts and operational practices;

5. Prepare contracts and legal documents for the Program as requested by the Board;

6. Be familiar with and provide assistance to the Board concerning all litigation and other disputes involving the Program and its operations;

7. Maintain a written record of all questions received and responses provided, and provide copies of all such responses to the Board of Directors; and

8. Assist the Board in other legal-related matters that the Board deems necessary.

D. Audit Committee

The mission of the Audit Committee shall include the following items, as well as any other appropriate tasks assigned to it by the Board:

1. Develop a uniform audit program to be utilized by independent auditors in their review of items related to reinsurance with the Program and assessments;

2. Establish standards of acceptability for the selection of independent auditors with regard to 1. above;

3. Assist the Board in the selection of an independent auditor for the annual audit of the Program operations;

4. Assist the Board in the review of the reports prepared by the independent auditors in conjunction with 1. and 3. above; and

5. Assist the Board on any other audit-related matters the Board deems necessary.

IX Article IX - Administering Carrier (33-22-1819(3)(b), MCA)

A. The Board shall select the Administering Carrier. The Board will develop a Request for Proposal that will outline the duties and responsibilities of the Administering Carrier. The Administering Carrier will be selected based upon written Proposals submitted. The proposals shall be in writing and provide, at a minimum, a detailed explanation of the work to be performed, the capabilities of the applicant and the costs anticipated.

B. The Administering Carrier shall perform the following functions as directed by the Board:

1. Establish procedures and install the systems needed to properly administer the operations of the Program in accordance with the Act and this Plan of Operation.

2. Establish on behalf of the Program one or more bank accounts for the transaction of Program business. These bank accounts will be approved by the Board.

3. Accept, on behalf of the Program, risks that are ceded by Members.

4. Collect reinsurance premium for ceded risks and collect all other amounts due to the Program on a timely basis.

5. Collect and maintain materials related to the calculations of reinsurance premiums and reinsurance claims to assure the ability to audit these functions.

6. Deposit all cash collected on behalf of the Program in the established bank account(s) on a timely basis.

7. Perform reinsurance reimbursement for claims paid on ceded risks.

8. Issue checks or drafts on and/or approve charges against bank accounts of the Program.

9. Keep all accounting, administrative, and financial records of the Program in accordance with this Plan.

10. Act as a communications resource for Members in reviewing their administrative operation under this Act and this Plan of Operation.

11. Calculate the assessment, in accordance with the methodology specified in this Plan of Operation, and collect appropriate amounts due.

12. Invest available cash in marketable securities as specified in this Plan and as approved by the Board.

13. Prepare an annual estimate of operating costs for the administration of Program operations.

14. Perform other functions as agreed between the Board and the Administering Carrier.

15. Periodically calculate reinsurance claims incurred but not yet paid.

C. The Administering Carrier shall maintain all records as to premiums claims, reimbursements, and administrative expenses as to a calendar year for a period of seven years following the end of such calendar year.

D. The Administering Carrier shall serve until the appointment by the Board of a successor Administering Carrier, until its resignation, or until it is otherwise removed by the Board. At its Annual Meeting, the Board shall vote whether to renew its contract with the Administering Carrier. The Administering Carrier shall give the Board one hundred and eighty (180) days notice of the Administering Carrier's decision to resign, and the Board shall give the Administering Carrier forty-five (45) days notice of its decision to remove the Administering Carrier.

E. The Administering Carrier shall be reimbursed for its reasonable costs of administration in accordance with any agreement approved by the Board.

F. The Administering Carrier will subcontract for services which cost in excess of $5,000 dollars only with the prior approval of the Board.

G. In performing hereunder, the Administering Carrier shall retain the confidentiality of all information pertaining to insureds and Members in accordance with all applicable statutes, regulations and principles of common law pertaining to confidentiality and trade secrets including, without limitation, the Montana Insurance Information and Privacy Protection Act. Such information shall be used only for the purposes necessary for the operation of the reinsurance Program, and shall be strictly segregated from other records, data, or operations of the Administering Carrier. Unless specifically required, hereunder or under the Act, no information shall be retained or used by the Administering Carrier or disclosed to any third party which information identifies specific insureds or Program Members.

X Article X - Reinsurance

A Small Employer Carrier may obtain reinsurance for Health Benefit Plans with the Program, provided the provisions of this Article are met. The Carrier may apply for reinsurance on a group basis or on an individual basis, as described herein.

A. Reinsurance for Small Employers Only.

1. Reinsurance is available only for Health Benefit Plans provided to Small Employers. An employer must qualify as a Small Employer under applicable Montana statutes and regulations as of the effective date of the Health Benefit

Plan, or the Plan anniversary date coincident with or immediately preceding the application for reinsurance with the Plan.

2. When an Employer fails to qualify as a Small Employer on two consecutive Plan anniversary dates, all reinsurance provided by the Program will terminate as of the second anniversary date in which the employer fails to qualify as a Small Employer.

3. At each initial application by the Member for reinsurance for a Health Benefit Plan with the Program, and as of any Plan anniversary date of a Plan that is reinsured, the Member must obtain documentation from the sponsoring firm that the firm is a Small Employer and certify in writing that such documentation has been obtained and agree to make it available to the Administering Carrier. A determination that a Member has erroneously certified a firm to be a Small Employer will nullify any reinsurance issued or renewed as a result of that determination.

B. Requirements of Health Benefit Plans Reinsured With the Program

These requirements must be met by any Health Benefit Plan that is reinsured with the Program. Any violation that, in the Board's opinion, may have a negative impact on the financial results of the program, will nullify any reinsurance issued or renewed for that Plan.

1. Requirements used by a Small Employer Carrier in determining whether to provide coverage to a Small Employer, including, but not limited to requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all Small Employers that have the same number of Eligible Employees and that apply for coverage or receive coverage from the Small Employer Carrier. *[33-22-1811(3)(d)]*

2. A Small Employer Health Benefit Plan in effect before January 1, 1994, may not be reinsured by the Program until January 1, 1997, and then only if the Board determines that sufficient funding sources are available. *[33-22-1819(5)(f)]*

3. A Member shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and non reinsured Health Plans that it provides to Small Employers. *[33-22-1819(5)(g)]*

4. The premium charged by the Member to the Small Employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in Montana Code Section 33-22-1809. *[33-22-1819(7)]*

5. The Health Benefit Plan must define the class of employees of the Small Employer that are covered, or who may elect coverage, by the Plan in writing on or before the effective date of coverage provided by the Plan. The classification of employees must include all Eligible Employees and must be in terms relating to conditions of employment, including, but not limited to, job classification, number of hours of scheduled

work, length of service, etc. The classification must not be in violation of Montana law, must be available to other Small Employers with the same number of Eligible Employees, and must be consistently applied to all employees within the plan.

6. The terms of these provisions of the Health Benefit Plan must be in writing, must comply with Montana law, must be available on the same terms to all Small Employers with the same number of Eligible Employees, and must be consistently applied to all individuals covered by the Plan:

   a. Takeover Provisions

   b. Pre-existing Condition Limitations

   c. Waiting Periods

   d. Coverage for Late Enrollees

   e. Definition of Dependent

   f. Services covered and benefits payable by the plan

C. Reinsurance Ceding Rules and Premium Levels

1. Each Member proposing to reinsure coverage provided under a Small Employer's plan for any group or individual is responsible for ascertaining and certifying:

   a. that the plan is provided to a Small Employer;

   b. that the individuals proposed for reinsurance are covered by the Health Benefit Plan;

   c. that the reinsurance premium rate level payable to the Program for the reinsurance has been correctly determined in accordance with this Plan of Operation; and

   d. the Health Benefit Plan meets all other requirements of the Act and the Plan of Operation.

   Each Member must also document these determinations in its reporting of reinsurance census data and reinsurance premiums to the Administering Carrier.

2. A Member must notify the Administering Carrier of its intent to cede all Eligible Employees, Extra Eligible Employees, and Dependents (Whole Group) for reinsurance of coverage under a plan covering Eligible Employees of a Small Employer within 60 days of the initial effective date of the Small Employer's plan with such Member.

   Availability of whole group reinsurance is subject to the following rules:

   a. Subject to payment of premium, all enrollees eligible to be reinsured, will also be reinsured at the effective dates of their coverage.

   b. If a Member has previously withdrawn reinsurance of

coverage for any group, the Member cannot again reinsure the withdrawn group but may reinsure timely enrollees that are eligible to be reinsured on an individual basis described in 4 below.

c. An amendment rider or other change in the Small Employer Plan shall not constitute a change in initial effective date.

d. The 60 day period in which a Member has to seek reinsurance with the Program shall be used to review underwriting requirements taken at the time of application for insurance to determine ceding to the Association. Only underwriting requirements taken at the time of application may be used by a Member in determining whether to reinsure with the Program. Group claim experience during the 60-day period shall not be used in determining whether to reinsure a risk to the Association.

3. A Member must notify the Administering Carrier of its intent to cede individual reinsurance of coverage for a specific person covered under a Small Employer's plan as an Eligible Employee, Extra Eligible Employee, or a Dependent within 60 days of the initial effective date of that person's coverage.

Availability of individual reinsurance is subject to the following provisions:

a. Each person whose coverage is reinsured must be an Employee or his/her Dependent.

b. The Member may reinsure coverage of an employee without reinsuring coverage of any specific dependent of that employee, or may reinsure coverage of a specific dependent without reinsuring coverage of the employee or his/her dependents.

c. The Member cannot reinsure a newborn child, unless the child's mother is already reinsured at the time of birth.

d. If a Member has previously withdrawn reinsurance of coverage for any individual, the same Member cannot again reinsure that individual.

e. The 60 day period in which the Carrier may cede any Eligible Employee and/or Eligible Dependent shall be used to review underwriting requirements taken at the time of application for insurance to determine ceding to the Program. Individual claim experience during the 60-day period shall not be used in determining ceding to the Program.

D. Level of Coverage

A Small Employer Health Insurance Benefit Plan can only be reinsured for coverage up to the full benefit level for:

1. the Standard Health Benefit Plan offered by the Small Employer Carrier,

2. Basic Health Benefit Plans offered by the Small Employer Carrier, or

3. the Standard Health Benefit Plan for plans that are neither Basic nor Standard Health Benefit Plans.

E. Period of Reinsurance

1. Reinsurance may continue as long as coverage under the Small Employer Health Plan for the Covered Employee and Dependents remains in effect, but reinsurance will end on the second plan anniversary after a Small Employer ceases to be a Small Employer.

2. Pursuant to 33-22-1819(5)(e), MCA, a Member may withdraw a group or individual from the Program even if the coverage continues to be in effect under the Small Employer's plan. Withdrawals will be effective on a plan anniversary. Written notice must be provided at least 30 days in advance of the withdrawal.

3. Reinsurance of an individual's coverage under a Small Employer's plan ceases at the termination of the individual's status as a covered Employee or Dependent (e.g., at retirement or other termination of active employment, divorce of a spouse, or a child's attainment of age 19, or termination of full-time student status after age 23, etc.), except to the extent that coverage continues as required by law. If the Member provides coverage for such persons beyond either of the dates indicated above, for contractual or other reasons, reinsurance will be available for a maximum of 30 days beyond said date.

4. Reinsurance ceases for any coverage of an individual covered under a Small Employer's plan (including an individual whose coverage under that plan has continued as required by law) at termination of the Member's coverage of the group in which that individual was previously covered as a covered Employee or Dependent.

F. Determination of Reinsurance Premium

1. Pursuant to 33-22-1819(6)(a), MCA, tables of reinsurance premium rates for Members, as determined by the Actuarial Committee and recommended by the Board, and approved by the Commissioner, will be communicated to Members. Separate tables will be prescribed for HMO's plans and indemnity plans.

2. For any reinsured individual, the reinsurance premium is 500% of the rate established by the Program for that classification or individual within a group with similar characteristics and coverage. The Member will calculate the reinsurance premium for each individual reinsured based on the Program's tables of reinsurance premium rates.

3. For any reinsured group, the reinsurance premium is 150% of the rate established by the Program for groups with similar characteristics and coverage. The Member will calculate the reinsurance premium for each group reinsured based on the Program's table of reinsurance premium rates.

G. Billing and Payment

1. Reinsurance bills will be handled on a "self-billed" basis. Monthly, the Member will provide the Administering Carrier with a listing of the individuals reinsured and the premium for each individual and such other information as may be required by the Program. The Administering Carrier will make any necessary corrections and send the corrected statement to the Member.

2. The reinsurance premiums charged by the Program for each individual will be determined by the Table of Rates in effect on the later of the effective date of the Small Employer's plan with the Member or the most recent plan anniversary.

3. Premiums are determined as of the first of the month and are due by the twentieth of the month.

4. Reinsurance premium amounts are to be paid based on whole month increments only. If reinsurance is effective between the 1st and the 15th of the month, the entire month is paid in full. When reinsurance becomes effective between the 16th and the last day of the month, no premiums will be payable until the first month following the effective date.

5. Conversely, terminations effective between the 1st and the 15th of the month will be allowed refunds for the entire month, and terminations effective between the 16th and the last day of the month will not be allowed a premium refund.

6. Reinsurance premium is due monthly to the Program regardless of the Member's ability to charge back or collect the Small Employer's premiums. The Program has no responsibility for the collection of Small Employer's premiums.

H. Reinsurance Claim

1. Statement of Reinsurance

The Program shall indemnify Members for the Covered Claims incurred with respect to employees and dependents whose coverage with the Member is reinsured with the Program as described in the Act and subject to the following:

a. The Association will reimburse a Reinsuring Insurer for Covered Claims, provided that no payments will be made unless the accumulated amount due to the Reinsuring Insurer for all reinsured individuals as of the end of any month exceeds $50,000. Regardless of this limitation, all balances due will be paid by the Association to Members no less often than every six months.

b. Covered Claims for an individual for each calendar year are based on the carrier's claims incurred in that calendar year according to the terms of the reinsured Health Benefit Plan.

Covered Claims are subject to a $5,000 deductible for each reinsured individual. In addition, the Member is responsible for 20% of the next $100,000 of Covered Claims during a calendar year subject to $25,000 maximum limit in any calendar year for any one individual. Once the $25,000 maximum limit is reached, the Program pays

100% of Covered Claims in that calendar year.

These deductible amounts shall be reviewed by the Board annually and shall be adjusted to reflect increases in costs and utilization within the standard market for Health Benefit Plans within the state. However, said adjustment may not be less than the annual change in the medical component of the Consumer Price Index for all urban consumers of the United States Department of Labor, Bureau of Labor Statistics, unless the Board proposes and the Commissioner approves a lower adjustment factor.

2. General Requirements

a. The Members agree that they will promptly investigate settle or defend all claims arising under the risks reinsured and that they will forward promptly to the Program copies of such reports of investigation as may be requested by the Program.

b. Members will adjudicate all claims on ceded risks.

c. The Members agree to use their normal case management programs to control costs on reinsured business to the same extent that they would use such programs on their unreinsured business, including but not limited to, utilization review, individual case management, and preferred provider provisions. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Board.

d. The Program shall have the right, at its own expense, to participate jointly with a Member in the investigation, adjustment or defense of any claim. Members will be required to assure that their claim management practices are consistent for reinsured and non-reinsured risks. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Board.

e. The Program shall have the right to inspect the records of the Member in connection with the risks reinsured with the Program and the Member shall submit to the Program any additional information it may require in connection with claims submitted to the Program for reimbursement. Members shall secure necessary authorizations from insureds for this purpose.

f. All information disclosed to the Program by the Member or to the Member by the Program, in connection with this Plan, shall be considered to be privileged information by both the Member and the Program.

g. If any payment is made by the Program and the Member is reimbursed by another party for the same expenses, the Program shall be reimbursed to the extent that the Member is reimbursed. The Member shall execute and deliver instruments and do whatever is necessary to preserve and secure such reimbursement rights.

h. HMO's or other Members which pay for certain provider services on a basis other than fee for service will be allowed reimbursement for those costs on reinsured persons from the Program through a methodology approved by the Board.

i. Except as approved by the Board, reinsurance will be provided only for Covered Claims submitted within two years from the date the expenses on which the claim is based were incurred.

3. Claims Reporting

a. Within 20 days after the close of each quarter or month as the Members desire, the Members shall furnish to the Program the following information with respect to reinsured losses submitted to the Program by the Member during said month:

(1) the Small Employer's identification;

(2) the employee's name and social security number;

(3) the claimant's name and date of birth;

(4) the claim incurral date and paid date;

(5) the reinsurance claim amount; and

(6) the claim coding as required by the Board (e.g., CPT and ICD9).

Members shall notify the Program as soon as reasonably possible of all claims or potential claims for a reinsured employee or dependent where the losses expected to be paid by the Members will exceed $100,000 in the aggregate.

XI Article XI - Audit Functions

A. Each Member of the Program shall hire a Certified Public Accountant (CPA) or other party approved by the Board to conduct audits of various items related to Program reinsurance and assessments. To be acceptable, the auditor must be independent, in accordance with standards established by the Audit Committee. The audits must be made in accordance with generally accepted auditing standards as adopted by the membership of the American Institute of Certified Public Accountants.

B. The audits shall be conducted in accordance with a uniform audit program for Program Members, as developed by Audit Committee and approved by the Board. The audit program shall clearly specify all items to be audited. It shall include a certification statement form, to be completed by the auditor, to verify the completion of all prescribed audit procedures as dictated by the audit program. Also, details regarding the number and types of records reviewed and any errors found shall be submitted in a report which accompanies the certification statement. A copy of this report and the certification statement shall be submitted to the Board by the auditor. The State Auditor shall provide staff support to the Board as requested by the Board.

C. The audit program shall include, but not be limited to, detail testing of representative samples of the following items:

1. Reinsurance claims submitted to the Program, in particular:

   a. Eligibility of claimants and their Small Employers for reinsurance by the Program including consistent application of business conduct rules.

   b. Proper determination of reinsurance claim amount by the Member.

2. Reinsurance premiums submitted to the Program, including:

   a. Eligibility of those lives for whom premium is paid for reinsurance by the Program.

   b. Proper determination of reinsurance premium amounts paid.

3. Data submitted to the Program for use in the calculation of Member assessments for net losses.

4. The frequency of these audits shall be determined by the Audit Committee. The cost of the audit of a Member shall be borne by that Member.

D. Random audits of provider bills or other records shall be conducted as deemed necessary by the Audit Committee to verify the accuracy and appropriateness of reinsurance claim submissions.

E. The Board shall have the right to conduct such additional audits of Members as it deems appropriate.

F. All information disclosed in the course of the audit of a Member company shall be considered privileged information by the Member company, the auditing firm and the Program.

G. The Program shall have an annual audit of its operations conducted by an independent Certified Public Accountant, as approved by the Board. The Board shall file this annual audit with the Commissioner for his review.

This audit shall encompass at least the following items:

1. the handling and accounting of assets and money for the Program;

2. the annual fiscal report of the Program;

3. the application of the premium rates charged for reinsurance by the Program;

4. the calculation and the collection of any assessments of Members for net losses; and

5. the reinsurance premiums due to the Program and the claim reimbursements made to the Members.

XII Article XII - Assessments

A. Interim Assessments

The Board may, if approved by the Commissioner, pursuant to 33-22-1819(8)(c), MCA, make interim assessments against Assessable Carriers. Each Assessable Carrier shall contribute to the interim assessment in an amount equal to the ratio of the total premiums earned in the previous calendar year from Health Benefit Plans delivered or issued for delivery by each Assessable Carrier divided by the total premiums earned in the previous calendar year from Health Benefit Plans delivered or issued for delivery by all Assessable Carriers in the state. Interim assessments shall be allowed as offsets to annual assessments.

B. Net Fund Earnings

Each year, the Program's net earnings shall be determined. Net earnings are earned reinsurance premiums plus investment income plus prior assessments in excess of need, less administrative and investment expenses, incurred claims, expense allowances paid, and taxes incurred. If the net earnings are negative (i.e., the Program has operated at a loss), the loss shall be recovered by assessments from the Assessable Carriers as set forth in (C) and (D) below.

C. Annual Assessments

Pursuant to 33-22-1819(8)(a) and (b), MCA, prior to March 1 of each year, the Board shall determine and report to the Commissioner the Program net operating results for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses. To the extent permitted by federal law, each Assessable Carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by each Assessable Carrier divided by the total premiums earned in the previous calendar year from Health Benefit plans delivered or issued for delivery by all Assessable Carriers in the state.

If the Board determines the assessments needed to fund the losses incurred by the Program in the previous calendar year will exceed five percent of total premiums earned in the previous calendar year from Health Benefit Plans delivered or issued for delivery to Small Employers in this state by Small Employer carriers, the Board shall evaluate the operation of the program and report its findings, including any recommendations for changes to this Plan of Operation, to the Commissioner within ninety days following the end of the calendar year in which the losses where incurred. The evaluation must include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of Member retention of risk under the Program and the costs of coverage for Small Employers. If the Board fails to file a report with the Commissioner within ninety days following the end of the applicable calendar year, the Commissioner may evaluate the operations of the Program and implement amendments to the Plan of Operation the Commissioner determines necessary to reduce future losses and assessments.

D. Special Limits

The Commissioner may abate or defer, in whole or in part, the assessment of an Assessable Carrier if, in the Commissioner's

opinion, payment of the assessment would endanger the Assessable Carrier's ability to fulfill its contractual obligations. In the event an assessment against an Assessable Carrier is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other Assessable Carriers in a manner consistent with the bands for assessments set forth in the Act. The Assessable Carrier receiving the abatement or deferral remains liable to the Program for the deficiency.

A Member receiving a deferment may not reinsure an individual or group until the assessment is paid.

E. De Minimis Assessments

Any assessment of less than $100.00 shall not be billed to a Assessable Carrier, but will be accumulated as a deferred assessment until the cumulative amount deferred exceeds $100.00. Any assessment of less than $10 shall be forgiven.

G. Late Payments

Assessments shall be paid when billed. If the assessment is not received by the Administering Carrier within 30 days of the billing date, the Assessable Carrier shall pay interest on the assessment from the billing date at the annual rate of prime plus 3%. The Board may suspend reinsurance rights if payments are not made in accordance with this article.

H. Special Rules for HMO's

An appropriate adjustment will be made to that portion of an HMO's earned premiums obtained from Health Benefit Plans sold to Small Employers in recognition of the Federal Health Maintenance Organization Act requirements including but not limited to:

1. No pre-existing condition exclusion; and

2. Required HMO benefits in excess of the typical health care benefits offered to Small Employers.

The adjustment formula will be approved by the Board for the interim assessments and will be annually reevaluated.

XIII Article XIII - Reports of Members and Administering Carrier

A. Information Required by Program

1. Unless otherwise specified by the Board, the following information shall be required by the Program for reinsured risks:

a. identification of the Member;

b. name, date of birth, and the Member identification number of the person being reinsured;

identification of the reinsured as an employee, spouse, child and/or dependent;

employee name (if different) and social security number or other identification number;

e. plan anniversary date;

f. employer's name, address, zip code and SIC code;

g. plan version;

h. effective date of Small Employer coverage;

i. effective date of reinsurance;

j. date of applicable employee's employment;

k. status code as required by the Board; and

l. other information required by the Board.

2. Changes in Reinsurance Coverage require the following information:

a. the reinsured's name and identification number;

b. the employee's name (if different) and social security number;

c. effective date of status change;

status code for change as required by the Board; and

d. other information required by the Board.

XIV Article XIV - Finsncial Administration

A. Books and Records

The Administering Carrier shall maintain the books and records of the Program and submit financial statements to satisfy the Act. A copy of all financial information shall be provided to the Commissioner as requested. Further, these books shall satisfy any additional requirements as may be deemed necessary to meet the needs of the Board and the outside auditors.

1. The receipt and disbursement of cash by the Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when the asset or the liability should be realized by the Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to/from the Program shall be calculated for each Member and confirmed with Program Members as deemed appropriate by the Board or when requested by the respective Program Member. These balances should be supported by a record of each individual Member's financial transactions with the Program. These records include:

a. assessments, if applicable to the particular Member;

b. allocated net earnings/losses of the Program based upon the assessments;

c. any adjustments to assessments;

d. the amount of reinsurance premium due to the Program for risks ceded and accepted by the Program;

e. the amount of reimbursement due from the Program for claims paid by the Member for risks previously ceded and accepted by the Program;

adjustment to the amount due to/from the Program based upon corrections to the Member submissions;

interest charges due from the Member for late payment of amounts due to the Program; and

f. such other records as may be required by the Board.

5. The Program shall maintain a general ledger whose balances are used to produce the Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

B. Handling and Accounting of Assets and Money

Money and marketable securities shall be kept in bank accounts and investment accounts as approved by the Board. The Administering Carrier shall deposit receipts and make disbursements from these accounts.

C. Bank Accounts

All bank accounts/checking accounts shall be established in the name of the Montana Small Employer Health Reinsurance Program, and shall be approved by the Board of Directors. Authorized check signers shall be approved by the Board.

D. Lines of Credit

All lines of credit shall be established in the name of the Montana Small Employer Health Reinsurance Program, and shall be approved by the Board of Directors. Lines of credit shall be used to meet cash shortfalls.

E. Investment Policy

All cash shall be invested in available investment vehicles deemed appropriate by the Board so long as in compliance with investment standards as specified in 33-2-801 et. seq., MCA.

XV <u>Article XV - Penalties/Adjustments and Dispute Resolution</u>

A. Penalties/Adjustments

1. Given numerous factual determinations and tasks to be performed by Members relative to their participation in the Program, it is expected that all Members will exercise the highest degree of good faith and due diligence in all aspects of their relationship with the Program. Errors will occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

2. Errors related to reinsurance:

   a. Reinsuring Ineligible Small Employers: Reinsurance coverage for the individuals involved shall be terminated as of the first date of ineligibility. Claims paid by the Program in excess of premiums received are to be returned to the Program with interest. Premiums paid in excess of claims will be refunded without interest. An administrative charge established by the Board will be assessed in such situations.

   b. Reinsuring employees/dependents at the incorrect premium rate (failure to use correct Program rates and/or to apply correct rates to persons reinsured): Reinsurance premiums for the persons involved should be recalculated and immediate payment of additional premiums must be made, plus interest and an administrative charge. Excess payments will be refunded without interest, subject to the limitation on premium refund provision.

   c. Reinsuring incorrect plan: Premiums will be recalculated on the basis of the correct plan and all additional premiums due will be paid immediately, with interest and the administrative charge. Excess premiums will be refunded without interest and subject to the limitation on premium refunds provision.

   d. Submitting incorrect claim payments/submissions. The claim will be recalculated and any amount due to the Program will be repaid immediately, with interest. Adjustments of claim payments for amounts recovered by the Member under coordination of benefit, subrogation or similar provisions shall not be considered errors for which interest or any administrative charge shall be due.

3. Errors related to assessments: All Assessable Carrier errors related to the assessment shall require the immediate payment of additional amounts due plus interest calculated from the date such sum should have been paid, plus an administrative charge as established by the Board.

4. Errors not listed: All additional sums due to the Program as a result of errors made by Members or Assessable Carriers other than those listed above shall be paid immediately, with interest, on the applicable administrative charge.

5. Gross negligence and intentional misconduct: If the Board determines that the nature or extent of the errors related to the use of the reinsurance mechanism or otherwise by a particular Member evidences gross negligence or intentional misconduct, the Board may, after notice and a hearing, terminate some or all current reinsurance for the Member and/or suspend the right of the Member to use the reinsurance mechanism for an appropriate period of time. All such actions shall require the concurrence of the Commissioner before becoming effective. The Board will ensure, to the extent possible, that the suspension or termination of reinsurance for the Member shall not adversely affect individuals already insured by the Member.

6. Interest and Administrative Charges: All interest payments required under this Article shall be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment. The rate of interest and the administrative charge shall be established by the Board and may be waived by the Board. Errors reported by Members or Assessable Carriers within 90 days of their occurrence shall not be subject to interest or any administrative charges.

7. Limitation on Premium Refunds: All premium refunds due under this Article shall be limited to a period of 12 months from the date the error was corrected unless otherwise agreed to by the Board.

B. Member Appeal of Disputes to Board

The Administrating Carrier will act on behalf of the Board in the attempt to resolve disputes between a Member or Assessable Carrier and the Program; however, Members may request permission to appear before the Board at any time in connection with any dispute with the Program.

XVI Article XVI - Indemnification

A. Neither participation in the Program as Members, the establishment of rates, forms, or procedures nor any other joint or collective action required by the Act shall be the basis of any legal action, criminal or civil liability, or penalty against the Program or any of its Members.

B. Persons or Members made a party to any action, suit, or proceeding because the person or Member serves on the Board or on a committee or was an officer or employee of the Program shall be held harmless and be indemnified by the Program against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding.

This indemnification shall not be provided on any matter in which the person or Member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all Members.

XVII Article XVII - Amendment

Amendments to this Plan may be suggested by any Member and may be made by the Board at any time. Amendments to this Plan shall be subject to the approval of the Commissioner.

XVIII Article XVIII - Termination

The Program shall continue in existence subject to termination in accordance with the requirements of a law or laws of the State of Montana or the United States of America. In case of enactment of a law or laws which in the determination of the Board and the Commissioner shall result in the termination of the Program, the Program shall terminate and conclude its affairs in a manner to be determined by the Board with the approval of the Commissioner. Any funds or assets of any nature held by the Program following termination and the payment of all claims and

expenses of the Program shall be distributed to the Program Members existing at that time in accordance with the then-existing assessment formula.

XIX Article XIX - Standards for Fair Marketing & Producer Compensation

In accordance with 33-22-1819, the following standards for fair marketing practices and minimum compensation levels are intended to ensure the broad availability of coverages, the objectives of the Program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, and the overall costs of coverage to small employers selecting these plans.

A. Each Small Employer Small Employer Carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a Small Employer Carrier denies coverage other than the basic or standard health benefit plans to a small employer on the basis of claims experience of the small employer or the health status or claims experience of its employees or dependents, the Small Employer Carrier shall offer the small employer the opportunity to purchase a basic or standard health benefit plan.

1. Each Small Employer Carrier shall provide all small employers in the same class of business an equal opportunity to obtain coverage under the Standard and Basic plans.

2. No Small Employer Carrier shall apply more stringent application or informational requirements for enrollment in the Standard and Basic plans than are applied for other health benefit plans offered by the Small Employer Carrier.

B. A Small Employer Carrier may select those insurance producers as defined in 33-17-103, with whom it chooses to contract. A Small Employer Carrier shall not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the Small Employer Carrier.

C. A Small Employer Carrier shall not price the basic and standard health benefit plans nor set the commissions in such a way as to make the plans unattractive for a producer to market.

1. A Small Employer Carrier shall provide reasonable compensation, as provided in the Plan of Operation, to a producer, if any, for the sale of a Basic or Standard Health Benefit Plan.

2. A Small Employer Carrier shall not set the commission levels for the sale of Basic and Standard Health Benefit Plans in each class of business at a level less than seventy-five (75) percent of the producer compensation schedule for the sale of other health benefit plans to small employers.

D. A Small Employer Carrier shall not limit, discourage, or otherwise influence the producer marketing the Basic and Standard Health Benefit Plans.

1. A Small Employer Carrier may not, directly or indirectly,

enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

2. D(1) of this article does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

3. D(1) of this article does not prohibit a Small Employer Carrier or a producer in the small employer market from providing a small employer with information about an established geographic service area or a restricted network provision of the health Small Employer Carrier.

E. A Small Employer Carrier or producer shall not directly or indirectly:

1. encourage or direct small employers to refrain from filing an application for coverage with the Small Employer Carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

2. encourage or direct small employers to seek coverage from another Small Employer Carrier because of the health status of the employers's employees or the claims experience, industry, occupation, or geographic location of the small employer; or

3. encourage or direct an employee not to apply for coverage under the Small Employer Health Plan in order to obtain a more favorable rate or benefit package for the employer.

F. A Small Employer Carrier or producer cannot delay the quotation of a rate to a group in order to avoid enrolling a high risk group.

1. A Small Employer Carrier shall provide a price quote or a request for additional information to a small employer, directly or indirectly through a producer, within 15 business days after receiving a request for a quote.

2. If additional information is necessary for the quote, a Small Employer Carrier shall provide the quote to a small employer, directly or indirectly through a producer, within ten business days after receiving the additional information.

G. Not withstanding the above, a Small Employer Carrier shall not engage in any practice which is inconsistent with the purposes of this Article XIX.

ATTACHMENT C

CONTRACT WITH TRAVELERS

Administrative Services Agreement

BY AND BETWEEN

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

(HEREINAFTER REFERRED TO AS THE "PROGRAM")

AND

THE TRAVELERS INSURANCE COMPANY OF ILLINOIS
CHICAGO, ILLINOIS

(HEREINAFTER REFERRED TO AS "TRAVELERS")

WHEREAS, Program desires Travelers to furnish certain administrative services with respect to the Plan of Operation of the Program,

NOW THEREFORE, in consideration of the mutual promises contained in this Agreement, Program and Travelers agree as follows:

Section 1: Definitions

(a) The term "Agreement" means Sections 1 through 12 and the attached Exhibit I.

(b) Additional terms as used herein are defined within Montana Code, Section 33-22-1818 and the Montana Small Employer Health Reinsurance Program's Plan of Operation.

Section 2: Administrative Services

During the term of this Agreement, Travelers will perform the services described in this Agreement and in Exhibit I attached hereto.

Services to be performed by Travelers under this Agreement may be performed by Travelers as Administrator. Travelers will subcontract with persons or entities other than Travelers or any of its affiliates or subsidiaries for services which are estimated to cost in excess of $ 5,000 only with the prior approval of the Board of Directors. Except as otherwise set forth in this paragraph, neither party may assign or delegate any of the rights and obligations hereunder to any third party without the prior written consent of the program.

Notwithstanding the foregoing, Travelers may sell, transfer, assign, or otherwise dispose of any or all of its rights or obligations in whole or in part with prior consent to a firm, person, corporation, or other legal entity controlling, controlled by, or under common control with Travelers so long as the other party to such sale, transfer, assignment or other disposition shall agree to be bound to the terms of this Agreement as it affects such sale, transfer, or assignment or disposition. For purposes of this Agreement, control shall be deemed to exist in the case of a stock company, if any person, directly or indirectly, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of another person.

(b) Travelers shall have sole discretion in determining whether any claim or assessment for taxes or assessments shall be paid, compromised, litigated or appealed and as to all matters of procedure, compromise, defense or appeal or any other aspects of any claim or assessment concerning its liability.

(c) In the event that a state or other jurisdiction, in accordance with existing of future law, imposes upon Travelers the duty to act as agent for collection of any tax or assessment imposed on the Program with respect to any aspect of the Plan of Operation, or this Agreement, the Program will pay over any such taxes or assessments to Travelers when requested to do so by Travelers.

Section 7: Effective Date - Agreement Period

(a) This Agreement shall be effective as of December 1, 1994 for an initial Agreement Period of thirty - six (36) months.

(b) This Agreement shall continue automatically for successive Agreement Periods of twelve (12) months each unless it is discontinued in accordance with Section 9.

Section 8: Administrative Service Charges

(a) Charges for the services provided under this Agreement shall be in accordance with the Schedule of Services and Charges set forth in Exhibit 1. The charges specified in Exhibit 1 shall apply for the initial Agreement Period and any subsequent Agreement Periods, unless a different period of application is set forth in Exhibit 1 or unless the charges are modified in accordance with Subsection (b) or (c) of this Section 8. Such Administrative Service Charge and any applicable taxes imposed with respect to said Charge or the services provided under this Agreement are due in advance on the first day of each quarter and shall be payable by Program to Travelers within thirty-one (31) days of the due date.

(b) Travelers shall have the right to change the Administrative Service Charge upon 30 days advance written notice to Program as follows:

(i) as of the effective date of any changes to the Plan of Operation,

(ii) as of the effective date of any change in law, regulations or rules which affect the obligations of Travelers under this Agreement.

(c) Either party to this contract shall provide to the other party, the opportunity for discussion in advance of changes to the Plan of Operation or changes to the law, as well as changes to the Administrative Service Charge.

(d) Within thirty (30) days of the end of each agreement period, Travelers may report to (MTSEHRP) as to the need and basis for any adjustments to the administrative services charges. In the event of unforeseen or material changes in the program, or the method of providing services

under this agreement, as demonstrated in such report, the parties agree to negotiate in good faith to reach agreement on appropriate adjustments to the administrative service charge, which adjustments shall become effective thirty (30) days following the date of a written agreement setting out the adjustments.

Section 9: Discontinuance of Agreement

(a) This Agreement shall discontinue at the earliest time specified below:

(i) as of any date agreed to by the Program and Travelers,

(ii) as of the due date of any charges or fees provided in this Agreement if Program fails to pay that fee or charge, when payable as described in Section 8 (a).

(iii) as of the one hundred and eightieth day after Travelers gives notice to that affect to Program,

(iv) as of the one hundred and eightieth day after notice to that effect to Travelers.

(b) Both parties agree to collaboratively modify this agreement to comply with any changes to state or federal law or regulations, however it is understood by the parties that changes in laws or regulations may require the operations of the Program to cease or may make the continued operation of the Program unnecessary. It is therefore agreed that in the event operations of Program cease or become unnecessary as the result of the Statutes, regulations, rules or actions of any federal or state government or agency thereof, the Termination Charge stated in Schedule 1 will be due upon the termination of this Agreement. Said charge shall be in addition to any other fee due in accordance with this Agreement and is due and payable as described in 8 (a).

(c) Discontinuance of this Agreement shall not terminate the rights or liabilities of either party arising prior to discontinuance.

Section 10: Choice of Law

This Agreement shall be governed by the laws of the State of Montana.

Section 11: Amendment and Waiver

(a) Any amendments or modifications to this Agreement must be in writing specifically referencing and amending this Agreement and must be signed by the duly authorized representatives of both parties.

(b) No term or provision of this Agreement shall be deemed waived and no breach excused, unless such waiver or consent to the breach is in writing and signed by the party claimed to have waived or consented.

Section 12: Entire Agreement

This Agreement constitutes the entire agreement between the parties and supersedes any prior agreement between the parties in connection with the subject matter contained in this Agreement whether oral or written.

IN WITNESS WHEREOF, the Program and Travelers have caused this Agreement to be executed in duplicate by their duly authorized representatives.

Dated at _____

This ____ day of _____

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

By Board of Directors

Dated at HARTFORD, CONNECTICUT

This 31ST day of OCTOBER, 1994

THE TRAVELERS INSURANCE COMPANY OF ILLINOIS

By _____

Title Second Vice President

Exhibit 1

Schedule of Services and Charges

The services include establishing carrier contacts with the program; processing of reinsurance notifications; reinsurance setup; maintenance of reinsurance, including termination and withdrawal of risks; reinsurance premium processing; claims reimbursement; reinsurance accounting; financial planning and reporting; investment and tax services.

Services will be charged in accordance with the schedule shown below:

Year	Fixed Fee	CSEHRP System	Per In Force Reinsured Life/Month	Termination Fee
1	$15,000	$5,000	$ 7.00(500 lives)	$ 14,000
2	$30,000	-	$ 7.00(500 lives)	$ 12,000
3	$39,000	-	$ 7.00(500 lives)	-

In the third year, the parties will evaluate costs and if there are any savings through economies of scale or other action or event, then the third year fee shall be reduced to reflect such savings. However, in no event will the third year fee be greater than the stated amount in the schedule above, unless the Program specifically request the performance by the Administering Carrier of additional functions not addressed in this contract.

Should the monthly reinsured lives exceed 500, the graduated monthly reinsured life rates stated in the proposal would become effective. Changes for the flat fee will be billed at the beginning of each quarter in advance. The services and charges included here assume the use of the CSEHRP Reinsurance forms and procedures and the payment by the Program to CSEHRP of a separate one-time licensing fee of $ 5,000. Should the reinsurance in force exceed 50 lives for an entire quarter, the automated system may be used at the discretion of the Administering Carrier with the prior approval of the Montana Board and the remaining $ 45,000 of one-time charges would be payable on a scheduled basis as required by CSEHRP.

Specific services are:

- Provide carrier communications including maintenance of a mailing list.
- Provide a toll-free telephone number for access by carriers.
- Respond to reinsurance questions by carriers.
- Maintain carrier status reports for each participating carrier including effective dates and impact on assessments and the carrier's eligibility to reinsure.

- Maintain and distribute the Operations and Procedures Manual which will be the source for rules, conditions, and procedures pertaining to reinsurance.

- Maintain information on reinsurance premiums, claims reimbursement, and paid assessments by carrier and report summary information to the Board. Maintain reinsurance activity for each carrier by type of plan and by type of reinsurance (individual or whole). Includes assessment calculations and billing/collection of assessments.

- Determine the net premiums, program expenses of administration, and the incurred losses, investment income, interest expense and report the financial results following the close of each fiscal year.

- Retain reinsurance transaction records for seven years. Maintain small employer carrier's market share information for assessment calculation purposes.

- Establish on behalf of the Program, one or more bank accounts for the transaction of Program business, invest available cash in marketable securities and draw from the line of credit to meet cash needs.

- Maintain control logs and reports for internal control purposes. Balance batch detail from reinsurance system to batch control log. Balance accounting system to reinsurance system.

- Review carrier monthly report and contact carrier for correction of error(s). Test reinsurance eligibility and validate reinsurance premium or claim reimbursement.

- Confirm reinsurance with carriers by reporting the policies and the reinsured risks accepted by the Program. This is done in lieu of issuing reinsurance policies. The Plan of Operation serves as the master reinsurance policy.

- Prepare an annual estimate of operating costs for the administration of the Program.

- Enter accounting data into accounting system. Report monthly cash receipts and cash disbursements activity. Report monthly cash basis financial results.

- Prepare Reinsurance accounting entries for the general ledger.

- Prepare for and conduct a Reinsurance Training Workshop in Connecticut at no cost. However, should you want a workshop conducted in Montana, actual time and travel will be charged separately.

- File tax returns for federal and state purposes.

ATTACHMENT D

REINSURANCE PREMIUM RATES

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PLAN

MONTHLY PREMIUM RATES - STANDARD PLAN
PLAN VERSION 1.0

GROUP RATES

PLAN CODE:	SGP	SGN	SGH
AGE	INDEMNITY WITH PPO	INDEMNITY WITHOUT PPO	HMO PLAN
UNDER 30	$ 58.61	$ 65.12	$ 62.75
30 - 34	$ 66.98	$ 74.43	$ 71.71
35 - 39	$ 75.36	$ 83.73	$ 80.68
40 - 44	$ 83.73	$ 93.03	$ 89.64
45 - 49	$ 92.10	$102.33	$ 98.61
50 - 54	$104.66	$116.29	$112.05
55 - 59	$129.78	$144.20	$138.94
60 - 64	$154.90	$172.11	$165.84
65+	$185.88	$206.58	$199.00
Per Child	$ 25.06	$ 27.84	$ 26.83
Medicare	$ 61.96	$ 68.84	$ 66.33

INDIVIDUAL RATES

PLAN CODE:	SIP	SIN	SIH
AGE	INDEMNITY WITH PPO	INDEMNITY WITHOUT PPO	HMO PLAN
UNDER 30	$195.37	$217.07	$209.16
30 - 34	$223.28	$248.08	$239.04
35 - 39	$251.18	$279.09	$268.92
40 - 44	$279.09	$310.10	$298.80
45 - 49	$307.00	$341.11	$328.68
50 - 54	$348.87	$387.63	$373.50
55 - 59	$432.60	$480.66	$463.15
60 - 64	$516.32	$573.69	$552.79
65+	$619.59	$688.43	$663.34
Per Child	$ 83.53	$ 92.81	$ 89.43
Medicare	$206.53	$229.48	$221.11

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PLAN

MONTHLY PREMIUM RATES - BASIC PLAN (1)
PLAN VERSION 1.0

GROUP RATES
(S500 deductible, 80/20 coinsurance to $7,500, 100% thereafter)

PLAN CODE:	G1P	G1N	G1H
AGE	INDEMNITY WITH PPO	INDEMNITY WITHOUT PPO	HMO PLAN
UNDER 30	$ 55.51	$ 61.68	$ 59.43
30 - 34	$ 63.44	$ 70.49	$ 67.92
35 - 39	$ 71.37	$ 79.30	$ 76.41
40 - 44	$ 79.30	$ 88.12	$ 84.90
45 - 49	$ 87.23	$ 96.93	$ 93.39
50 - 54	$ 99.13	$110.14	$106.13
55 - 59	$122.92	$136.58	$131.60
60 - 64	$146.71	$163.01	$157.07
65+	$176.05	$195.62	$188.49
Per Child	$ 24.43	$ 27.15	$ 26.16
Medicare	$ 58.68	$ 65.21	$ 62.83

INDIVIDUAL RATES
(S500 deductible, 80/20 coinsurance to $7,500, 100% thereafter)

PLAN CODE:	I1P	I1N	I1H
AGE	INDEMNITY WITH PPO	INDEMNITY WITHOUT PPO	HMO PLAN
UNDER 30	$185.04	$205.60	$198.11
30 - 34	$211.48	$234.97	$226.41
35 - 39	$237.91	$264.35	$254.71
40 - 44	$264.35	$293.72	$283.01
45 - 49	$290.78	$323.09	$311.32
50 - 54	$330.43	$367.15	$353.77
55 - 59	$409.74	$455.26	$438.67
60 - 64	$489.04	$543.38	$523.58
65+	$586.85	$652.05	$628.29
Per Child	$ 81.44	$ 90.49	$ 87.19
Medicare	$195.62	$217.35	$209.43

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PLAN

MONTHLY PREMIUM RATES - BASIC PLAN (2)
PLAN VERSION 1.0

GROUP RATES

(S1,000 deductible, 70/30 coinsurance to $10,000, 100% thereafter)

PLAN CODE: AGE	G2P INDEMNITY WITH PPO	G2N INDEMNITY WITHOUT PPO
UNDER 30	$ 49.00	$ 54.45
30 - 34	$ 56.00	$ 62.22
35 - 39	$ 63.00	$ 70.00
40 - 44	$ 70.00	$ 77.78
45 - 49	$ 77.00	$ 85.56
50 - 54	$ 87.50	$ 97.22
55 - 59	$108.50	$120.56
60 - 64	$129.50	$143.89
65+	$155.40	$172.67
Per Child	$ 23.51	$ 26.12
Medicare	$ 51.80	$ 57.56

INDIVIDUAL RATES

(S1,000 deductible, 70/30 coinsurance to $10,000, 100% thereafter)

PLAN CODE: AGE	I2P INDEMNITY WITH PPO	I2N INDEMNITY WITHOUT PPO
UNDER 30	$163.34	$181.48
30 - 34	$186.67	$207.41
35 - 39	$210.00	$233.34
40 - 44	$233.34	$259.26
45 - 49	$256.67	$285.19
50 - 54	$291.67	$324.08
55 - 59	$361.67	$401.86
60 - 64	$431.67	$479.64
65+	$518.01	$575.56
Per Child	$ 78.35	$ 87.06
Medicare	$172.67	$191.85

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PLAN

MONTHLY PREMIUM RATES - BASIC PLAN (3)
PLAN VERSION 1.0

GROUP RATES

(S2,000 deductible, 60/40 coinsurance to $15,000, 100% thereafter)

PLAN CODE: AGE	G3P INDEMNITY WITH PPO	G3N INDEMNITY WITHOUT PPO
UNDER 30	$ 41.39	$ 45.99
30 - 34	$ 47.30	$ 52.56
35 - 39	$ 53.22	$ 59.13
40 - 44	$ 59.13	$ 65.70
45 - 49	$ 65.04	$ 72.27
50 - 54	$ 73.91	$ 82.13
55 - 59	$ 91.65	$101.84
60 - 64	$109.39	$121.55
65+	$131.27	$145.85
Per Child	$ 21.21	$ 23.56
Medicare	$ 43.76	$ 48.62

INDIVIDUAL RATES

(S2,000 deductible, 60/40 coinsurance to $15,000, 100% thereafter)

PLAN CODE: AGE	I3P INDEMNITY WITH PPO	I3N INDEMNITY WITHOUT PPO
UNDER 30	$137.97	$153.30
30 - 34	$157.68	$175.20
35 - 39	$177.39	$197.10
40 - 44	$197.10	$219.00
45 - 49	$216.81	$240.90
50 - 54	$246.38	$273.75
55 - 59	$305.51	$339.45
60 - 64	$364.64	$405.15
65+	$437.56	$486.18
Per Child	$ 70.69	$ 78.55
Medicare	$218.78	$243.09

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PLAN

MONTHLY PREMIUM RATES - BASIC PLAN (4)
PLAN VERSION 1.0

GROUP RATES

($2,500 deductible, 50/50 coinsurance to $15,000, 100% thereafter)

PLAN CODE: AGE	G4P INDEMNITY WITH PPO	G4N INDEMNITY WITHOUT PPO
UNDER 30	$ 39.12	$ 43.47
30 - 34	$ 44.71	$ 49.68
35 - 39	$ 50.30	$ 55.89
40 - 44	$ 55.89	$ 62.10
45 - 49	$ 61.48	$ 68.31
50 - 54	$ 69.86	$ 77.63
55 - 59	$ 86.68	$ 96.26
60 - 64	$103.40	$114.89
65+	$124.08	$137.86
Per Child	$ 20.76	$ 23.07
Medicare	$ 41.36	$ 45.95

INDIVIDUAL RATES

($2,500 deductible, 50/50 coinsurance to $15,000, 100% thereafter)

PLAN CODE: AGE	I4P INDEMNITY WITH PPO	I4N INDEMNITY WITHOUT PPO
UNDER 30	$130.41	$144.90
30 - 34	$149.04	$165.60
35 - 39	$167.67	$186.30
40 - 44	$186.30	$207.00
45 - 49	$204.93	$227.70
50 - 54	$232.88	$258.75
55 - 59	$288.77	$320.85
60 - 64	$344.66	$382.95
65+	$413.59	$459.54
Per Child	$ 69.21	$ 76.90
Medicare	$137.86	$153.18

BASIC INDEMNITY PLANS' REINSURANCE PROGRAM PREMIUM RATES

GUIDE TO PROPER REINSURANCE PREMIUM RATE
BASED ON HEALTH BENEFIT PLAN'S BENEFIT VALUE

Boundary Basic Plan Description	Benefit Value Range	Monthly Reinsurance Premium Rate
Standard Plan - $250 deductible; 80/20 coinsurance, with $5,000 stoploss; 100/0 thereafter	(111.15, 126.40]	Standard Plan's Reinsurance Rate
Basic Plan (1) $500 deductible; 80/20 coinsurance, with $7,500 stoploss; 100/0 thereafter	(79.61, 111.15]	Basic Plan (1)'s Reinsurance Rate
Basic Plan (2) $1,000 deductible; 70/30 coinsurance, with $10,000 stoploss; 100/0 thereafter	(54.94, 79.61]	Basic Plan (2)'s Reinsurance Rate
Basic Plan (3) $2,000 deductible; 60/40 coinsurance, with $15,000 stoploss; 100/0 thereafter	(45.69, 54.94]	Basic Plan (3)'s Reinsurance Rate
Basic Plan (4) $2,500 deductible; 50/50 coinsurance, with $15,000 stoploss; 100/0 thereafter	Less than or equal to 45.69	Basic Plan (4)'s Reinsurance Rate

The premium used for each basic plan depends on the plan's benefit value. For example, a basic plan with a benefit value of more than 79.61 but less than or equal to 111.15 will be charged Basic Plan (1)'s reinsurance rate. This plan will be reinsured up to Basic Plan (1)'s level of reinsurance.

INSTRUCTIONS FOR REINSURANCE PREMIUM CALCULATIONS

Attached are reinsurance premium rate tables which include the following:

1. Monthly reinsurance premium rates.

Monthly reinsurance premium rates are given for (1) Individual Reinsurance (one or more individuals within a group are reinsured but not the entire group) and (2) Group Reinsurance (entire group is reinsured) for the Small Employer Groups.

For each person reinsured as Individual Reinsurance, the amount of monthly premium due is the Monthly Premium Rate. For Group Reinsurance, the calculation process is similar.

Use of group rates is limited to Small Employer groups whose risk for the entire group is ceded to the Program.

Age is defined as "age last birthday" as of the premium effective date. Children are defined to be age 19 or younger or, if full-time student, through age 23, or if a child of any age is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003.

Reinsurance premiums are based on whole month increments. If reinsurance is effective during the first 15 days of the month, the premium for the entire month is to be paid. If reinsurance is effective after the 15th of the month, no premium is payable until the following month. Terminations effective during the first 15 days of the month will be allowed a adjustment for the entire month. Terminations effective beyond the 15th of the month will not be allowed a premium adjustment for the month.

INSURANCE COMPANIES DECLARED TO BE IN SMALL GROUP MARKET

These are the insurers declared to be participating in the small business health insurance market in Montana. Those certified as small group carriers currently can offer insurance plans to small businesses. Those companies that are not yet certified may not have submitted policies to the Montana Insurance Department or their policies are being reviewed.

Company *(32 companies to date)*	**Certified as Small Group Carrier as of 2/23/95**
Aetna Life Insurance Co.	
American Chambers Life Insurance Co.	X
American National Insurance Co.	X
Bankers United Life Assurance Co.	X
Best Life Assurance Company of California	
Blue Cross Blue Shield of Montana & HMO	X
Celtic Life Insurance Co.	
Centennial Life Insurance Co.	
Connecticut General Life Insurance Co.	
Continental Life and Accident	
CUNA Mutual Insurance Society	X
Fortis Benefits Insurance Co.	X
Glacier Community Health Plan Inc.	
Golden Rule Insurance Co.	
Home Life Financial Assurance Corp.	X
John Alden Life Insurance Co.	X
John Hancock Mutual Life Insurance	X
Life Investors Insurance Co of America	X
Monumental Life Insurance Co	
National Group Life Insurance Co.	
New York Life Insurance Co.	X
PFL Life Insurance Co.	
Pioneer Life Insurance Company of Illinois	
Principal Mutual Life Insurance Co.	X
Security Life Insurance Company of America	
Time Insurance Co.	X
Travelers Insurance Co.	X
United of Omaha Life Insurance Co.	X
United World Life Insurance Co.	X
Universe Life Insurance Co.	X
Western Mutual Insurance Co.	
Yellowstone Community Health Plan	

ATTACHMENT F

ANNUAL REPORT 1994

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

ANNUAL MEETING

February 7, 1995

Room 209
Cogswell Building
Helena, Montana

AGENDA

STATE AUDITOR
STATE OF MONTANA

Mark O'Keefe
STATE AUDITOR

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

MONTANA SMALL EMPLOYER HEALTH REINSURANCE BOARD

Annual Meeting of February 7, 1995

Room 209, Cogswell Building
Helena, Montana

Board of Directors
Sherry Abel
Patrick Carmody &
Rebecca Smart
Mutual of Omaha
Hank Frantz
John Alden Life
Carl Halcro
Merle Pederson
& Martha Crist
Principal Mutual Life
Ray Havig
Western Mutual Insurance Company
Merlyn D. Colpron
Continental Life & Accident Company
Christian MacKay
Garth Trusler
William Jensen
MT Blue Cross/Blue Shield

A G E N D A

8:30 a.m. Convene
Activities of Reinsurance Pools Nationally - Karl Ideman
Report on small business market and status of small business carriers - Claudia Clifford

9:00 a.m. Legislative report
Discussion of premium rates and public comment

10:30 a.m. - 3:00 p.m. Required annual meeting agenda items
(Break at noon for lunch)

1. Review this Plan of Operation and submit proposed amendments, if any, to the Commissioner for approval.

2. Review reports of the Administering Carrier, including audited financial reports, reports on outstanding contracts and obligations, and all other material matters.

3. Review reports of the committees established by the Board.

Mitchell Building/PO Box 4009/Helena, Montana 59604-4009/(406) 444-2040/1-800-332-6148/FAX: (406) 444-3497

4. Determine whether any technical corrections or amendments to the Act shall be recommended to the Commissioner.

5. Review and give consideration to the performance of the Program in support of the goals of the Act.

6. Review the rates for reinsurance coverages, benefit plan design and communication programs.

7. Review the net premiums, the Program administration expenses and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

8. Determine if an assessment is necessary for the proper administration of the Program.

9. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the Program.

10. Review and evaluate the contracts and services with the administrating carrier and staff. With support of 5 directors of the board, the contract will be renewed.

3:00 p.m. Business survey of health insurance coverage

3:15 p.m. Review terms of office for board members

3:45. p.m. Approve minutes from previous meetings

4:00 p.m. Adjourn

ADMINISTERING CARRIER
ANNUAL REPORT

Montana Small Employer Health Reinsurance Program
Annual Report

Administering Carrier

- The Operations and Procedures manuals were sent to the general contact person at each reinsuring carrier that requested a copy. To date, we have mailed twenty eight manuals. This number does not include the manuals sent to the Board Members.

- The workshop was held on December 14th and 15th at the Montana Insurance Department, there were six attendees. Many of the same key contact people who are handling the other states have already attended workshops and therefore opted not to travel to the workshop. In addition to the orientation of reinsurance reporting, the process of automating carriers monthly reports was also discussed.

- No lives have been ceded to the Program to date. We expect to see reinsurance activity within the next few months since carriers have contacted us with questions regarding procedures on how to reinsure lives with the program.

- A December 31, 1994 Unaudited Financial Statement is included, along with Projected Operating Expenses for 1995.

- The Administering Services Agreement has been signed and there are currently no outstanding contracts or obligations.

Plan of Operation Proposed Changes/Additions

- Article X - Reinsurance
  Section C., #2. d. & 3. e. Addition to the Plan.
  Consideration may be given to allow the administering carrier to grant exceptions to newly designated Reinsuring Carriers. If they provide us with a valid written explanation, notification of a Carrier's **first** reinsured group or individual may be accepted up to 21 days beyond the normal 60 day notice. Request for exception for late notification must be supported by documentation that the ceding decision made and the information for that ceding decision was available before the notification date, unless otherwise agreed to by the Board. The Administering Carrier will report any such exception to the Board.

cont'd.

- Section E., #2. Change to the Plan.
  Consideration may be given to delete "withdrawals will be effective on a **plan anniversary"** from this section and substitute "withdrawals may be effective at any time with a thirty day advance notification".

- Section G., #3. Addition to the Plan
  Consideration may be given to add a statement with regards to late reinsurance premiums as follows:
  Interest on late premiums will be charged at 1.5% per month.

- Article XIV - Financial Administration
  Section A., #2. Changes to the Plan
  Consideration may be given to change the wording to read as follows:
  2. Non-cash transactions shall be recorded when the asset is purchased or the liability is incurred by the Program in accordance with generally accepted accounting principles

ADMINISTERING CARRIER
MONTHLY REPORT

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

January 23, 1995

To: Montana Small Employer Health Reinsurance Program Board of Directors

From: The Travelers

Subject: Administering Carrier Report

This report covers reinsurance activity through the December monthly reporting period. It also covers some key events that have taken place since the Program became operational. There are no items requiring immediate Board action.

No lives have been ceded to the Program, no premium has been received. One carrier has requested further information on the reinsurance forms.

Some key events during December were as follows:

- We mailed a General Contact Person Request form to all insurance companies from the list provided to us by Claudia Clifford, Health Care Policy Specialist, Montana Insurance Department. Included on this form was a section that requested whether the carrier intended to reinsure with the Program and if they needed a manual. The Montana Small Employer Health Reinsurance Program Operations and Procedures manual was sent to the contact person at each Reinsuring Carrier that responded positively to our request form. In addition, each carrier was invited to attend the workshop. Many of the same key contact people who are handling the other states have already attended prior workshops and therefore opted not to travel to the workshop.

- The workshop was held at the Montana Insurance Department on December 14th and 15th and the attendees were given an orientation to reinsurance reporting as well as an opportunity to discuss issues and to ask questions.

We expect to see reinsurance activity within the next few months since carriers have contacted us with questions on reinsuring lives with the program.

A financial statement as of December 31, 1994 is attached.

UNAUDITED
FINANCIAL REPORTS

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

STATUTORY STATEMENT OF ADMITTED ASSETS,
LIABILITIES AND MEMBERS' ACCOUNTABILITY - STATUTORY BASIS
as of December 31, 1994
(UNAUDITED)

ADMITTED ASSETS

Total admitted assets	$0

LIABILITIES

Payable to Administering Carrier	1,917
License Fee Payable	5,000
Total liabilities	6,917

MEMBERS' ACCOUNTABILITY

Members' accountability	(6,917)
Total liabilities and members' accountability	$0

MONTANA SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

STATEMENT OF LOSS AND MEMBERS' ACCOUNTABILITY - STAUTORY BASIS
For twelve months ended December 31, 1994
(UNAUDITED)

Underwriting Revenues:	$0
Losses and Expenses:	
Administering Carrier Expense	1,917
Licensing Fee Expense	5,000
Total losses and expenses	6,917
Net Loss	6,917
Members' accountability, December 31, 1994	$6,917

Montana Small Group Health Reinsurance Program
Estimated 1995 Budget

Administering Fees	$15,210.00
Licensing Fees	$5,000.00
Travel	$4,000.00
Bank Fees	$150.00
Audit Fees	$2,500.00
	$26,860.00

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